



PATIENT

Fefe Trixie Bell
Roberson

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

14.5 Years

WEIGHT

12.5 Pounds

INTERPRETED BY

Tam Mengine, DVM,
DABVP (canine/feline
practice)

**IMAGING
PERFORMED BY**

Dr. Christina Sitton

HOSPITAL NAME

Sherwood Family PC

REFERRING VET

Dr. Christina Sitton

INVOICE

46008

DATE

3/17/23

PRESENTING CLINICAL SIGNS

Not eating over last 72 hours >1 pound weight loss over last month behavior/vocalization changes
Abnormal PE/Chem/CBC/UA Results: Lab 1 month ago showed fPLi 10.1 was 9.4 on 1/25/23 (0-3.5)
otherwise wnl

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra (visible to 3.0 cm) are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal). The left kidney measured 4.0 cm. The right kidney measured 3.9 cm.

Adrenal Glands

The adrenal glands are not distinctly visualized due to the presence of inflammation in the region.

Spleen

The spleen appears diffusely enlarged with scalloped borders. There is a 1.0 cm target lesion present within the splenic body. The spleen measures 1.6 cm in thickness at the hilus. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

Liver

The liver appears subjectively enlarged with rounded borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. There is a 2.2 cm inhomogeneous mass in the cranial portion of the liver. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents and a small amount of freely-moveable echogenic sludge. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal

The stomach is empty. The gastric wall is normal in thickness (2.3 mm) with normal deviations due to rugal folds and exhibits appropriate wall layering. The pylorus is of normal appearance.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. Intestinal motility appears normal. Duodenum wall measures 2.9 mm. Jejunum wall measures 2.4 mm.

The visible portions of the colon are of normal thickness (1.7 mm) with intact wall layering. The ileocecal junction is not visualized.

Pancreas

The entirety of the pancreas is swollen and hypoechoic, surrounded by hyperechoic mesenteric fat. The pancreatic duct appears dilated.



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Free Abdomen

There is a large amount of hypoechoic fluid present throughout the abdomen. The omentum and intraabdominal fat are hyperechoic. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

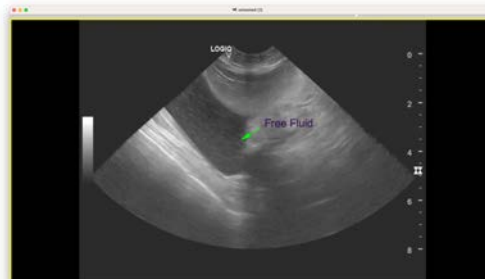
ULTRASONOGRAPHIC FINDINGS

- Thickened spleen with target lesion
- 2.2 cm inhomogeneous liver mass
- Marked pancreatic inflammation
- Diffuse peritonitis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes in the liver and spleen are concerning for infiltrative neoplasia. The pancreatic changes may represent acute pancreatitis, but pancreatic neoplasia cannot be ruled out. Additional recommendations include:

- Ultrasound guided fine needle aspirate of the spleen and hepatic lesion with a 25-gauge needle after pre-medicating with diphenhydramine in case of mast cell disease.
- Fine needle aspiration of the pancreas could also be considered.
- 3-view chest radiographs are recommended.





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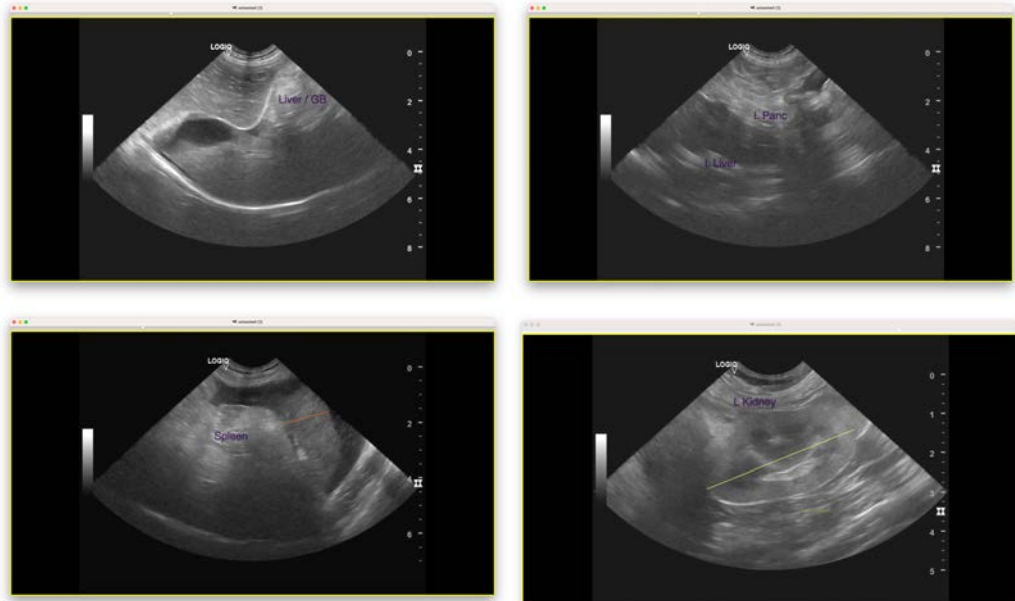
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Tam Mengine, DVM, DABVP (canine/feline practice)

info@SonoPath.com